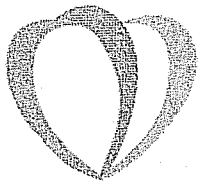

Long Island Select Healthcare

159 Carleton Avenue, Central Islip, NY 11722-4172 Phone: 631.493.4300 Fax: 631.439.4379
62 Pine Street, East Moriches, NY 11940-1117 Phone: 631.878.9328 Fax: 631.878.7807
250 Marcus Blvd, Hauppauge, NY 11788-2018 Phone: 631.232.0011 ext 612 Fax:
221 North Sunrise Hwy Service Road, Manorville, NY 11949-9604 Phone: 631.878.8900 ext 163 Fax: 631.874.2100
883 East Main Street, Riverhead, NY 11901-2613 Phone: 631.284.5500 Fax: 631.369.7421
75 Landing Meadow Road, Smithtown, NY 11787-1124 Phone: 631.360.4700 Fax: 631.863.3626

Welcome Packet

Your Assigned Treatment Coordinator is: _____

Hours of Operation

Clinical services will be offered at 159 Carleton Avenue Central Islip, NY 11722 8:00a.m - 8:00p.m.; 62 Pine Street East Moriches, NY 11940 9:00am – 3:00pm; 250 Marcus Blvd Hauppauge, NY 11788 8:00am – 4:00pm; 221 North Sunrise Hwy Service Road Manorville, NY 9:00am – 3:00pm; 883 East Main Street Riverhead, NY 11901 8:00am – 4:00pm; 75 Landing Meadow Road Smithtown, NY 11787 8:00am – 4:00pm. If you need scheduling at any of these locations, please call 631.439.4371.

Emergency Contact Information: **After Hours Call Service** 631.566.3004

Patients rights and responsibilites

It is the policy of Long Island Select Healthcare(LiSH) to protect and promote the rights of persons served.

A. No individual shall be deprived of a civil or legal right solely because of a diagnosis of developmental disability.

B. Each individual shall be given the respect and dignity that is extended to all people regardless of race, religion, national origin, creed, age, gender, ethnic background, developmental disability, HIV status, AIDS or another handicap.

C. These rights are intended to establish the living and/or program environment for people that protect them and contribute to providing an environment in keeping with the community at large, to the extent possible, given the degree of disability of any individual. Rights that are self-initiated or involve privacy or sexuality issues may need to be adapted to meet the needs of people with the most severe handicaps and/or individuals whose need for protection, safety, and health care may justify such adaptation. **Long Island Select Healthcare** will ensure that individual rights are not arbitrarily denied. Limitations of peoples' rights shall be on an individual basis and for clinical purposes. The clinical justification and specific period of time the limitation is to remain in effect shall be contained in the individual's Plan of Services.

D. An individual shall have the right to:
A safe and sanitary environment.
Freedom from physical or psychological abuse.
Freedom from corporal punishment.
Freedom from unnecessary use of mechanical restraining devices.
Freedom from unnecessary or excessive medication.

Protection from commercial or other exploitation.

Confidentiality with regard to all information contained in the individual's record, and access to such information, subject to the provisions of Article 33 of the Mental Hygiene Law and the Commissioner's regulations. In addition, confidentiality with regard to HIV related information shall be maintained in accordance with Article 27-F of the Public Health Law, 10 NYCCR Part 63 and the provisions of Section 633.19 of this Part.

The opportunity, either personally or through parent(s), guardian(s), or correspondent, to express, without fear of reprisal, grievances, concerns, and suggestions to any of the following: The CEO of the facility, the Commissioner of OPWDD, the Commission on Quality of Care; for people in developmental centers and in the community on conditional release from a developmental center, the Mental Hygiene Legal Service and the Board of Visitors, and for people in the developmental centers, the Ombudsman.

Implementation of many of the above rights entails inherent risks to people. To the extent reasonable, foreseeable, and appropriate under the circumstances, such risks shall be described to individuals and/or their parents, guardians or correspondents. However, individuals assume responsibility for those risks typically associated with participation in normal activities, to the extent the person's abilities permit such participation.

Grievance Procedure

An individual or the client's parent(s), guardian(s), or correspondent(s) may object to the application, adaptation, or denial of any of the previously stated rights made on his/her behalf in accordance with Section 633.12

The client, parent/guardian/correspondent shall have the opportunity to express, without fear of reprisal, grievances, concerns, and suggestions to any of the following parties:

Program Director
Long Island Select Healthcare
159 Carleton Avenue
Central Islip, NY 11722

Practice Manager
Long Island Select Healthcare
159 Carleton Avenue
Central Islip, NY 11722

Chief Executive Officer
Long Island Select Healthcare
159 Carleton Avenue
Central Islip, NY 11722

Director of the DDSO
45 Mall Drive
Commack, N.Y. 11725
(631) 493-1700

Commissioner of OPWDD
New York State OPWDD
44 Holland Avenue
Albany, New York 11229
(518) 473-1997

Contact Information:

Treatment Coordinator:

Susan Pfundstein
Long Island Select Healthcare
159 Carleton Avenue
Central Islip, NY 11722
Phone: 631 650.2194
Fax: 631 650.0438

Sarah Pedersen
Long Island Select Healthcare
883 East Main Street
Riverhead, NY 11901
Phone: 631 650.1483
Fax: 631 369.7411

Long Island
Select Healthcare

Receipt Form

Name: _____ DOB: _____

Initial Each Statement:

_____ I have received the Hours of Operation

_____ I have received the Patients Rights and Responsibilities

_____ I have received the Grievance Procedure

_____ I have been Assigned a Treatment Coordinator

_____ _____

Patient or Representatives Signature Date

_____

Print Name of Representative

_____

Relationship to Patient

Long Island
Select Healthcare

Article 16 Referral Request

Patient Name: **TABS #:**

Person completing application/Relationship to applicant: _____

Service Coordinator Info (MSC):

Name: _____ Phone: _____

Agency: _____ Email: _____

Living Arrangements:

☐ Alone ☐ DSS/Foster Care ☐ Friends/Housemates ☐ Parents/Family ☐ Family Care Provider

☐ ICF ☐ IRA ☐ Other (please specify)

*If Agency, Agency Name and Contact Person: _____

Day Program Info:

Agency: _____ Phone: _____ ☐ Does not attend Day Prog.

Address: _____ Contact: _____

Medical Information:

Primary Care Physician's Name: _____ Phone #: _____

Address: _____

Allergies: _____

List of Medications: _____

Qualifying Diagnosis: _____ Documentation Present: ☐ Yes ☐ No

Seizure History (include type, frequency, date of last known seizure): _____

TB status: _____ Record of Two negative PPD's: Dates: _____ _____

Physical Limitations: _____

Service(s) Requested: ☐ OT ☐ PT ☐ SPEECH ☐ Wheelchair

Briefly describe the individual's need for each requested service: _____

Is the individual currently receiving OT, PT, Speech or Wheelchair services elsewhere? (to avoid duplication of services)

☐ *YES ☐ NO * If Yes, where?

****FOR OFFICE USE ONLY****

Prescription for services: After review of this information, it is my professional medical opinion that this individual sufficiently meets all admission criteria to receive services provided by the LISH Article 16 Clinic. This authorizes the performance of clinical evaluations necessary to develop a treatment plan.

☐ OT ☐ PT ☐ SPEECH ☐ Wheelchair

Comments: _____

Medical Director Signature: _____ Date: _____

Treatment Coordinator Assigned: _____

Long Island
Select Healthcare

ARTICLE 16 FINANCIAL AGREEMENT/CONSENT

Last Name First Name

Financial Agreement/Guarantor

For and in consideration of services rendered or to be rendered by LISH to the patient whose name appears above, (jointly, and severally, if more than one) hereby agree(s) to be fully and totally responsible to LISH for payment of charges as submitted by LISH on the account of said patient and to make payment in accordance with the policy of payment of bills at said LISH Facility. It is further agreed that charges as incurred represent the fair and reasonable value of the services rendered and are in accordance with the posted charged of LISH which are available upon request. Payment may be demanded at any time, and the failure to demand payment of the patient shall not be prerequisite to my/our immediate responsibility for payment. I/we will be personally liable for the individual in my/our capacity as an agent(s) for the patient.

Patient Authorization – Medicare

I authorize LISH to release to the Social Security Administration and its agents any medical or other information needed to determine this or a related Medical claim. This authorization is valid unless revoked in writing.

Insurance Benefits Assignment

I the undersigned, hereby authorize and direct the insurance carrier to pay LISH all benefits due under this insurance plan. I understand that acceptance by LISH of benefits under this policy shall not release/relieve the Guarantor of the responsibility for any remaining charges. I also understand that the Guarantor is responsible for any/all charges for services not covered by the policy or in excess of policy limits.

Authorization to Release Information

I authorize the release of any medical information necessary to process this claim. This authorization is valid unless revoked in writing.

Consent for Treatment

I the undersigned, authorize LISH physicians, dentists, allied health practitioners, nursing staff, assisted by other agents, servants and employees of LISH, to provide such medical, surgical, and/or dental care and to administer such diagnostic, radiological and/or therapeutic tests, procedures and treatments as, in judgment of the physician, dentist or other licensed professional personnel of said Center, may be deemed necessary or advisable in the event that I or the above named patient shall require such care and treatment.

(Sign on reverse)

Long Island
Select Healthcare

Last Name First Name

I have received a copy of:

1. Patient's Bill of Rights
2. Grievance Procedure

I hereby authorize the above named center to release any information requested by such insurance company pertaining to my medical treatment, or to process a claim.

I, the undersigned

→ ( ) PATIENT ( ) PARENT ( ) LEGAL GUARDIAN ( ) OTHER _____

have read the above, have been informed of its nature and significance and acknowledge the contents of same and have received a copy of this agreement.

_____

Guarantor's Name (PRINT) Guarantor's Signature Date

_____

Name of Person Authorized to Consent for Patient (PRINT) Signature of Person Authorized to Consent for Patient Date